



# STATE OF TENNESSEE

TennCare PCMH: Practice Transformation  
Training Informational Webinar

# TennCare PCMH Transformation – Introduction to Navigant and Training Activities

## AGENDA

- HCFA Program Objectives
- Partnership between HCFA, MCOs, Navigant and practices
- Introduction to Navigant
- Overview of Training Modalities
- Assessments and Coaching
- Key Milestones and Schedule
- Questions and Answers

# TennCare PCMH Program Overview

- Program start date was January 1, 2017
- Federally funded by a CMS State Innovation Model Program
- Goals:
  - Better serve members by increasing focus on primary care with goal of preventing unnecessary hospitalizations and emergency room visits
  - Use patient-centered medical home (PCMH) program approach to facilitate development of primary care practices as the center of their patients' medical networks to ensure patients receive integrated and seamless care across the entire health care system

# TennCare PCMH Program Overview

- Key Components:
  - *Patient-centered access* (e.g., providing same-day appointments for routine and urgent care)
  - *Team-based care* (e.g., holding scheduled patient care team meetings or a structured communication process focused on individual patient care)
  - *Population health management* (e.g., using data for population management to address chronic and acute care services)
  - *Care management support* (e.g., identifying high-risk patients for care management and care plans with self-care support recommendations for each)
  - *Care coordination and care transitions* (e.g., referral tracking and follow-up and coordinating care transitions)
  - *Performance measurement and quality improvement* (e.g., measuring and tracking performance on quality and efficiency measures)

# TennCare PCMH Program Overview

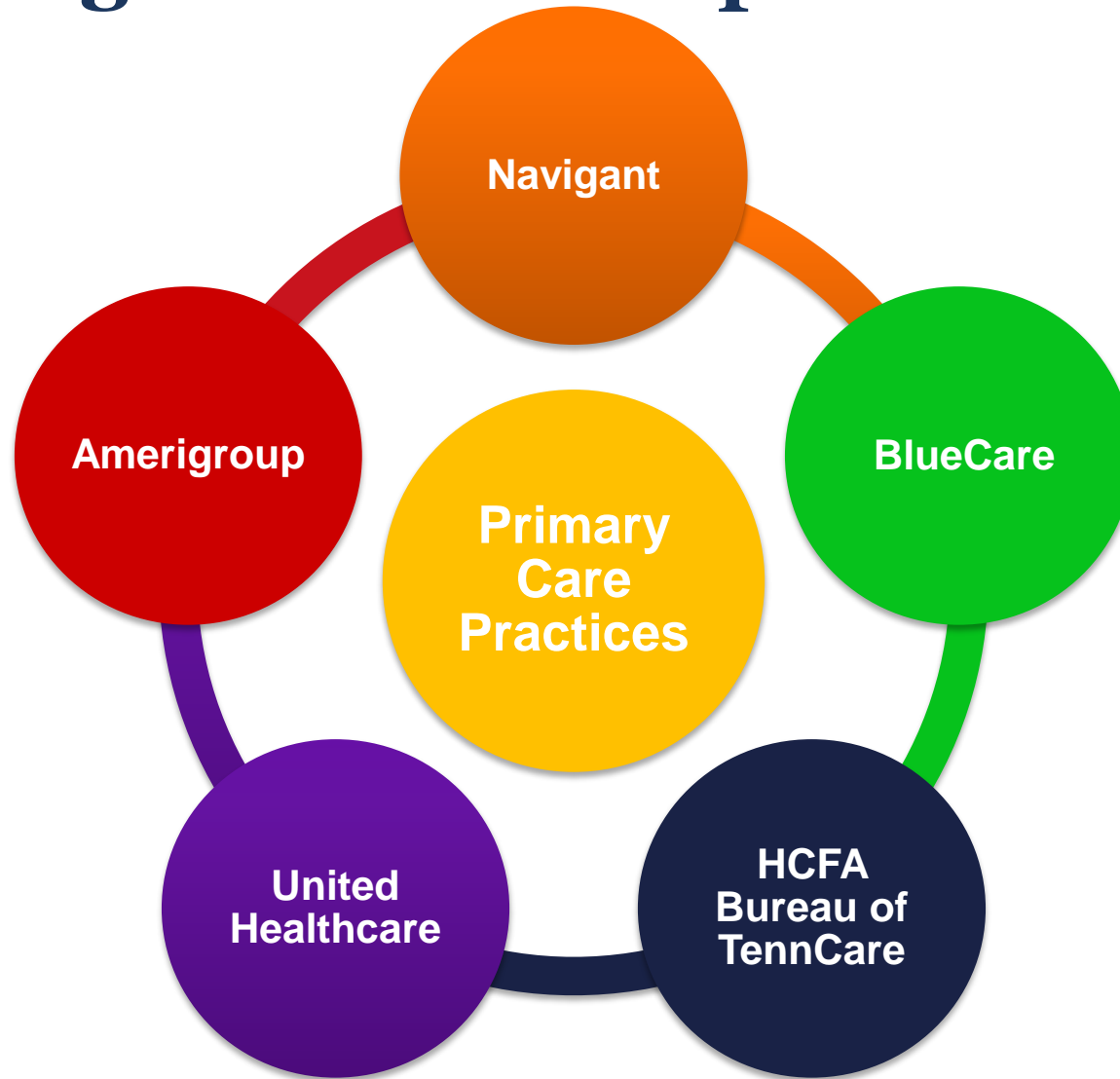
## Practice transformation support:

- Practices will receive direct financial support for their first program year:
  - Activity payment: A risk-adjusted per member per month payment to cover costs of support activities for panels of assigned members
  - Outcomes-based payment: Intended to provide financial rewards for practices that succeed in increasing both efficiency and quality. Acceptable quality outcomes must be achieved to receive bonus payments
- Practices will receive practice transformation training Navigant for their first two years in the program

## Further information about the TN PCMH Program:

<https://www.tn.gov/hcfa/article/patient-centered-medical-homes>

# Working in Partnership



# Navigant's Team



PCMH

Health Homes

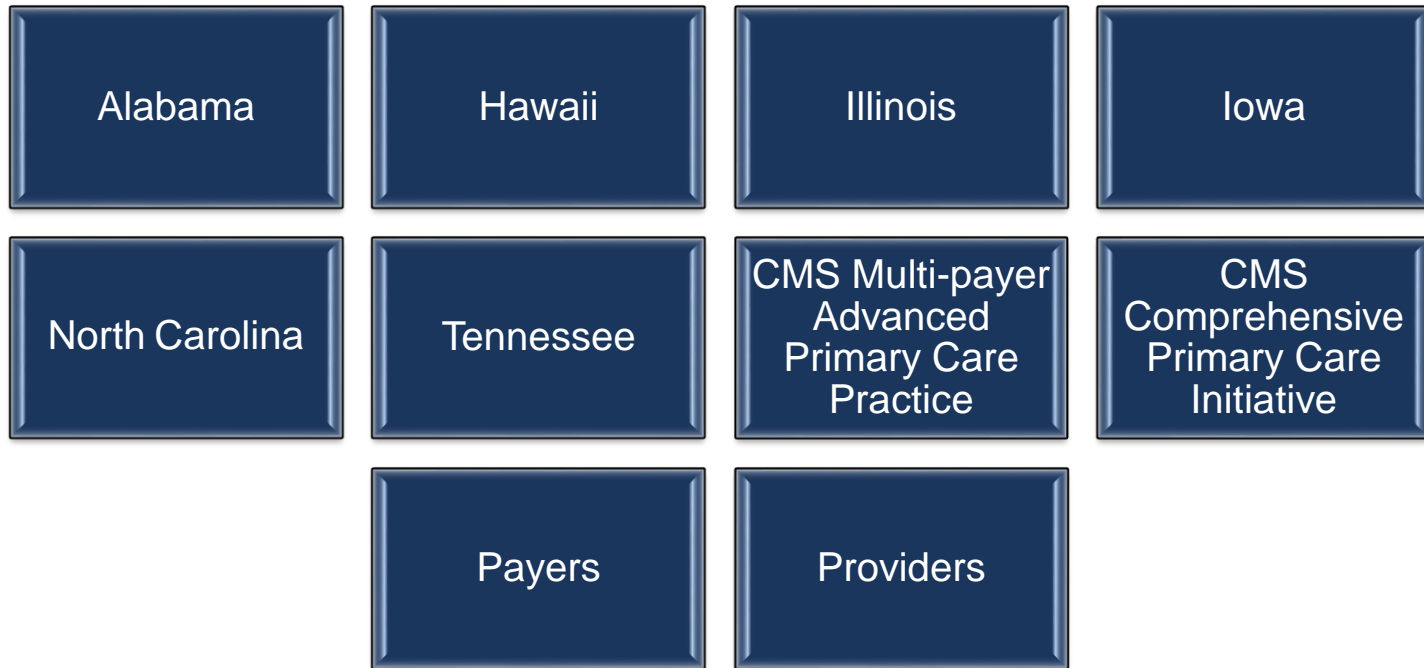
Healthcare  
Delivery  
Transformation

Stakeholder  
Engagement

Tennessee's  
Healthcare  
Environment

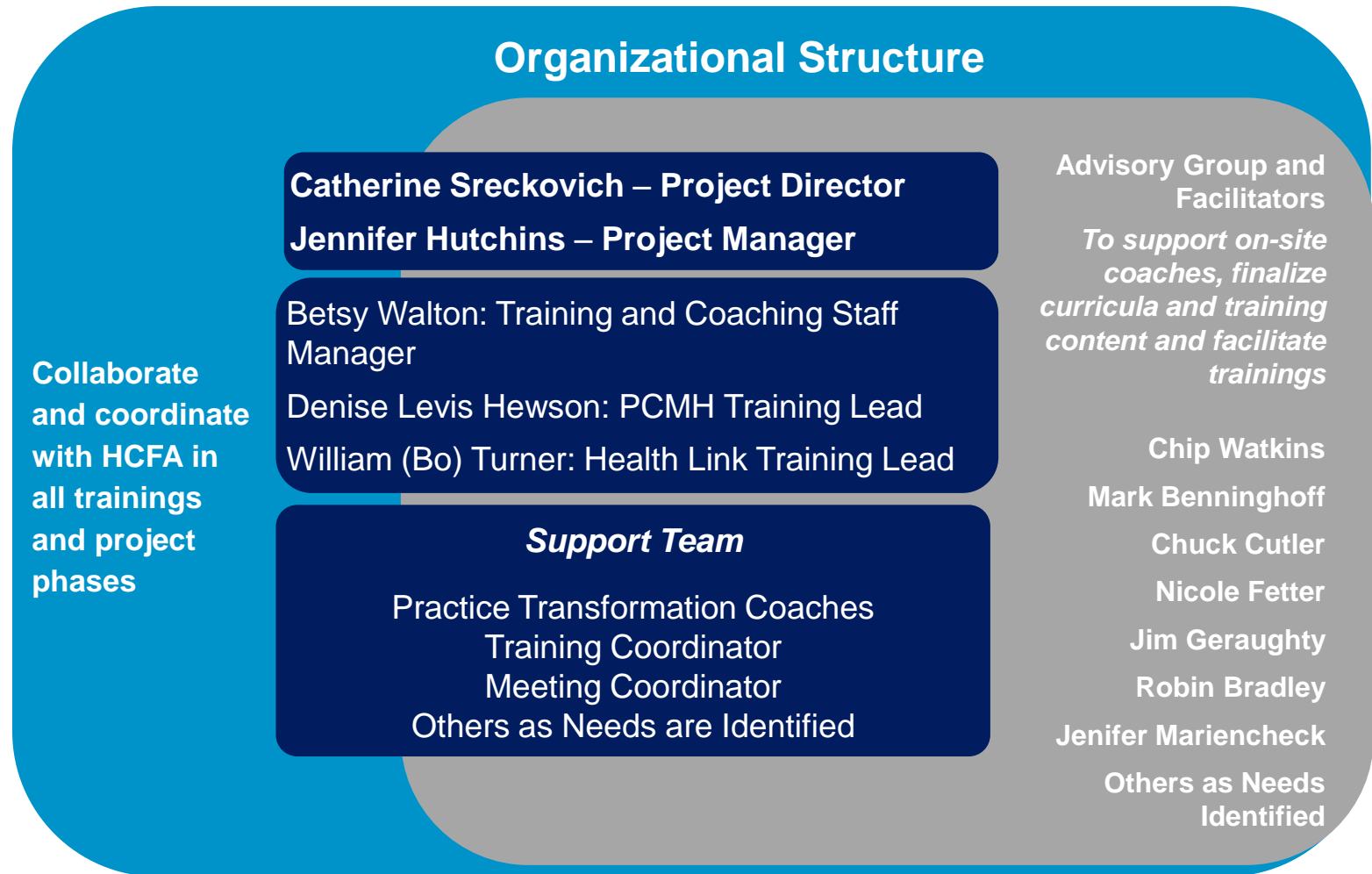
# Navigant's Team

Our team members have supported a variety of states, federal agencies and other entities with design, development and implementation of medical homes, health homes and other physical and behavioral health initiatives.





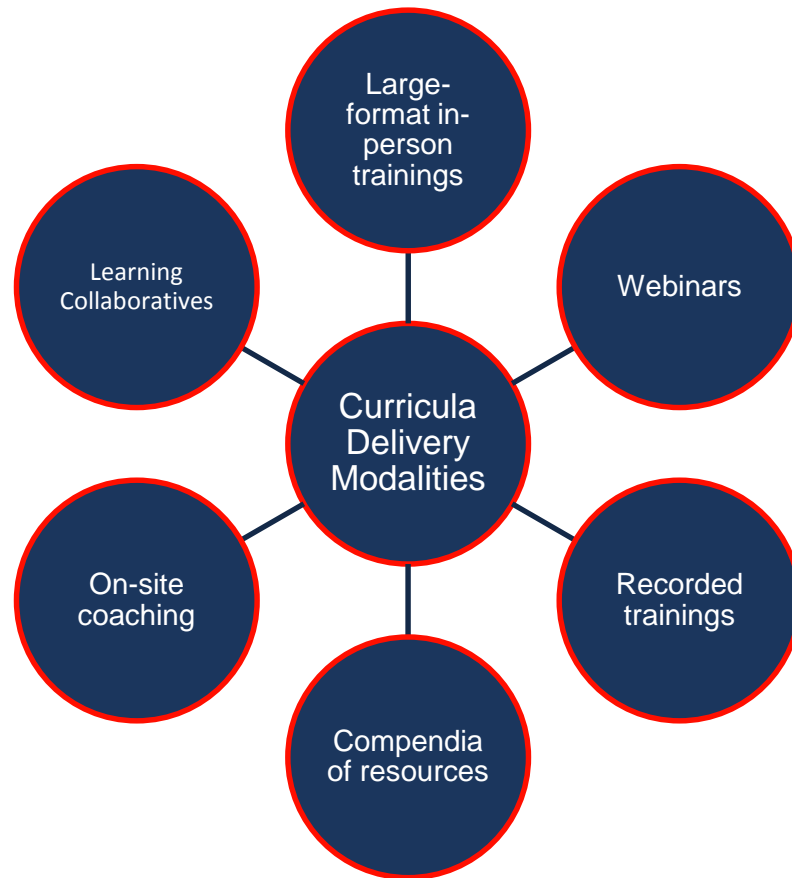
# Navigant's Team



# Transformation, Technical Assistance and Training

- Contracted through January 2020 to provide technical assistance and training to practices participating in the PCMH program
- Will conduct the following activities:
  - Practice outreach
  - Initial and semi-annual assessments
  - Ongoing coaching and other training opportunities
- Year 1 objectives include:
  - Achieving consensus on goals, needs and areas of focus
  - An agreed upon plan on how to achieve transformation
  - Active involvement and engagement to achieve defined goals
  - Progress on transformation

# Training and Technical Assistance Modalities



# Overview of Training Modalities

Modality	Description
Large Format Trainings	<ul style="list-style-type: none"> <li>• Will address topics that can benefit from in-person discussion and sharing of ideas among practices</li> <li>• Allow team time for practice staff</li> <li>• Mix of informational presentations and small group discussions</li> <li>• Will occur at least quarterly in each Grand Region</li> </ul>
Learning Collaboratives	<ul style="list-style-type: none"> <li>• Facilitate knowledge transfer among practices regarding successes, challenges, lessons learned and leading practices</li> <li>• Allow team time for practice staff</li> <li>• Hands-on sessions</li> <li>• Will occur at least quarterly in each Grand Region</li> </ul>
Webinars	<ul style="list-style-type: none"> <li>• Provide a remote platform for presentation of further instruction for specific topics</li> <li>• Provides opportunity for questions posed to experts</li> <li>• Will occur at least quarterly</li> <li>• Will be recorded</li> </ul>

# Overview of Training Modalities

Modality	Description
Recorded Trainings	<ul style="list-style-type: none"><li>• May be accessed at an individual's convenience (e.g., to support training new staff and training existing staff on new topic)</li><li>• Topics will be relevant to a large variety of providers across geographies</li></ul>
Compendia of Resources	<ul style="list-style-type: none"><li>• Materials will provided online to offer a large number of providers access to information and resources</li></ul>

# Examples of Assessment and Curricula Content Areas

Content Area	Sample Topics
Overview and Basics	Introduction to PCMH; Case for Practice Redesign; Stages of Transformation and Driver Diagram; Practice Assessment and Transformation Plan; Resources and Shared Learning; Sustainability
Change Management	Implementing a Change Management Model; Use of Change Management Knowledge to Prepare for Transformation; Leadership Role in Transformation
Team Based Care and Practice Organization	Team-based Care and Care Coordination; Role of Practice Team; Characteristics of Effective Teams; Assessing and Optimizing Care Teams; Common Challenges
Comprehensive Care Management and Support	Comprehensive Care Management; Population Health Management; Development of Integrated Care Plans; Improving Population Health through Health Promotion

# Assessment and Curricula Content

Content Area	Sample Topics
Care Coordination	Practice Workflow Redesign and Clinical Workflow Management; Coordination of Care Transitions; Co-management, Closed Loop Referrals; Test Tracking and Follow-Up; Enhanced Patient Access; Working with Specialists: Effective Use of CCT; Business Support
Behavioral Health Integration	Unique Population Characteristics of the Behavioral Health Patient Population; Behavioral Health Integration in the Pediatric Setting; Patient Screening
Patient Engagement and Self-Care Support	Effective Patient and Family Engagement; Support Self-Care and Shared Decision Making; Tracking Patient Satisfaction
Use of HIT, HIE and CCT	Introduction to EHRs and HIE; Effective Use of CCT; E-Prescribing; EHRs and Quality Improvement
Quality Improvement and Efficiency	Model for Improvement; Understanding Methodologies for Quality Improvement (KPIs, PDSA, Lean); Quality Improvement Tools; Total Cost of Care; Measurement and Use of Metrics; Effective Use of Provider Reports

# Anticipated Timeline and Events: Initial Assessments





# Assessment Philosophy and Approach

- Contact practices' designated PCMH Director
  - Discuss assessment intent and approach and schedule onsite assessment
  - Discuss need for multiple meetings for practices with large number of sites
- Recommend “Core Assessment Team” that is comprised of practice staff who attend the full assessment meeting:
  - Medical Director
  - Practice Manager
  - PCMH Director
  - Quality Improvement Director
  - Finance Manager
  - IT Support Lead
  - Care Coordinator/Care Manager
  - Office Staff Representative
  - Site Representatives
- One to two Navigant team members will attend the onsite assessment
- HCFA team members will attend as schedules allow
- Use Assessment Tool to facilitate discussion with Core Assessment Team

# Philosophy and Approach: Initial Assessments

- Estimate each onsite assessment will require 2-3 hours
- Conduct at practice level to determine current capabilities
- Some practices and their sites are further along in transformation than others
- Use findings as baseline to determine level and frequency of recommended support
  - Generate information on topics for:
    - Individual practice needs for coaching and support
    - Webinars
    - Collaboratives
    - Large conferences
  - Form baseline for monitoring performance improvement and progress at the practice, region and state levels

# Assessment Report Example

Scoring	
Low	L
Medium	M
Medium High	MH
High	H

## Access

Is the practice able to provide same-day appointments?	Your Answer	Region Answer Totals			
	L	L 15	M 15	MH 18	H 2

Does the practice support scheduling and reducing barriers to adherence for medical and behavioral health appointments?	Your Answer	Region Answer Totals			
	L	L	M	MH	H
	15	25	8	2	

Is the practice able to provide routine and urgent care appointments outside regular business hours?	Your Answer	Region Answer Totals			
	L	L	M	MH	H
		15	20	10	5

## Health Promotion and Self-Management

Does the practice educate the patient and his/her family on independent living skills with attainable and increasingly aspirational goals?	Your Answer	Region Answer Totals			
M		( L )	( M )	( MH )	( H )
		3	32	10	5

Does the practice provide educational resources, tracking tools and decision-making aids for self-management support?	Your Answer M	Region Answer Totals			
		L	M	MH	H
		10	20	15	5

# Philosophy and Approach: Coaching

- Each practice has opportunity to receive up to one two-hour onsite coaching session per month for two years
  - Frequency to be determined based on initial assessment and agreement with practice leaders
  - Sessions will be grouped where possible and applicable
- Individualized curricula to be developed to focus on practice needs
  - Sessions will focus on practical application of concepts explored during other training modalities offered
- Coaching may be relevant to both clinical and operational staff with requested attendance as relevant and determined by the practice

# Philosophy and Approach: Semi-Annual Assessments

- Conduct semi-annual assessments as more formal checkpoints than ongoing coaching sessions
- Use results to determine progress to date
- Based on progress, evaluate need for any changes to coaching or for corrective actions
- Develop findings reports

# Philosophy and Approach: Semi-Annual Assessments

- Conduct semi-annual assessments as more formal checkpoints than ongoing coaching sessions
- Use results to determine progress to date
- Based on progress, evaluate need for any changes to coaching or for corrective actions
- Develop findings reports

# Upcoming Milestones

## January 2017

- Begin practice outreach
- Begin webinars

## January - April 2017

- Schedule and conduct initial assessments
- Conduct conference

## Mid-April 2017

- Develop practice coaching plans
- Begin onsite coaching
- Develop Region Assessment summary for

# Navigant Email Address

- General questions and comments can be submitted to an email mailbox but your primary source for answering questions will eventually be your coaches

[providerassistance@navigant.com](mailto:providerassistance@navigant.com)





**THANK YOU**